Public Employees Benefits Board (PEBB) – Group #123731
Underwritten by ReliaStar Life Insurance Company

Life Insurance Enrollment Form

Use this form if you enroll within 60 days of initial eligibility.

Employees

If you're enrolling after 60 days of eligibility or making changes to your current PEBB life insurance (including after job transfers between agencies), use the *Life Insurance Change Form*.

- **Type or print clearly in black ink.**
- **Complete Sections 1-2 and 4-6 below. If you want additional coverage that requires approval, also complete Section 3 and the *Life Insurance Evidence of Insurability* form.**
- **Return form to your payroll or benefits office.**

Payroll or benefits office staff

- **Review Sections 1-6 for completeness and accuracy, and complete Section 7.**
- **Key Section 2 first, and then Section 3 (if chosen).**
- **If the employee completes Section 3, send the form to ReliaStar Life Insurance Company to obtain approval (address on back).**

SECTION 1: Personal Information *Employee completes this section.*

Social security number **(required)**	Last name	First name	Middle initial	Employee I.D. number

Street address	Apt. number

City	State	ZIP Code + 4	Phone number–Daytime	Phone number–Evening
			( )	( )

Date of birth	❑ Male ❑ Female	Do you or any family member you are requesting coverage for smoke? ❑ Yes ❑ No *If no, complete and sign Section 4.*

SECTION 2: Guaranteed Coverage *Employee completes this section.*

Employees do not need approval for coverage amounts below if enrolling within 60 days of initial eligibility. Additional Part B (Supplement Spouse) and Part D coverage is available in Section 3. If you want to estimate your costs for this coverage, complete the Monthly Costs column below. (See rates on page 32.)

Type of Coverage	Employee	Family	Estimated Monthly Costs
Part A—Basic Life *Paid by your employer, except if you're on Leave Without Pay.*	$25,000 life insurance $5,000 Accidental Death & Dismemberment	Not applicable	$0.00
Part B—Basic Spouse and Children Life	Not applicable	*Check all that apply:* ❑ Spouse or qualified domestic partner ($2,500) ❑ Children ($2,500 per child)	$0.52 per family per month
Part B—Supplemental Spouse Life	Not applicable	*Fill in desired amount (in increments of $1,000).* $ _____ Up to ½ of employee's total Part C and D coverage; maximum of $25,000 Spouse/qualified domestic partner must enroll in Part B Basic and employee must enroll in Part C, Part D, or both.	$_____
Part C—Optional Life	*Fill in desired amount (in increments of $1,000).* $ _____ Minimum of ½ of employee's gross annual pay up to employee's gross annual pay (based on full-time, 12-month pay; rounded up to nearest $1,000) **If you request the maximum gross annual pay only:** Do you want coverage to automatically increase as the pay increases? ❑ Yes ❑ No	Not applicable	$_____
Part D—Supplemental Life	*Fill in desired amount (in increments of $1,000).* $ _____ Minimum of $1,000 up to $50,000	Not applicable	$_____
Part E—Optional Accidental Death and Dismemberment	*Fill in desired amount (in increments of $25,000).* $ _____ Minimum of $25,000, up to $250,000	❑ Do or ❑ Do not include this coverage for my dependents. *(See page 32 for coverage amounts.)*	$_____
SUBTOTAL (Add to subtotal in SECTION 3, if requesting additional insurance)			$

continued on back

SECTION 3: Additional Life Insurance That Requires Approval From ReliaStar *Employee completes this section.*

Employee completes this section when applying for more than $25,000 of Part B Supplemental Spouse and/or more than $50,000 of Part D Supplemental Life. If approved, these amounts will be added to the guaranteed amounts in Section 2. If you want to estimate your costs for this coverage, complete the Monthly Costs column below. (See rates on page 32.)

Type of Coverage	Employee	Family	Estimated Monthly Costs
Part B— Supplemental Spouse Life *If enrolling, must also complete* Life Insurance Evidence of Insurability Form.	Not applicable	*Fill in desired amount. (in increments of $1,000).* $ _____ Additional amount over $25,000 up to ½ of employee's total Part C and Part D coverage	$_____
Part D—Supplemental Life *If enrolling, must also complete* Life Insurance Evidence of Insurability Form.	*Fill in desired amount. (in increments of $1,000).* $ _____ Maximum of $300,000	Not applicable	$_____
		SUBTOTAL	$_____
		SUBTOTAL FROM SECTION 2	+ $_____
		YOUR ESTIMATED TOTAL MONTHLY PREMIUM	$_____

SECTION 4: Nonsmoker Certification *Employee completes this section.*

To qualify for the nonsmoker's discount, the applicant(s) must not have used any tobacco products in the past 12 months.

I certify that I or any family member I am requesting coverage for have not smoked cigarettes, cigars, or pipes, or used chewing tobacco or nicotine gum within the past 12 months.

I understand that ReliaStar Life Insurance Company has the right to reduce claims payment if I provide false information or if I don't notify my payroll or benefits office that I no longer qualify for the nonsmoker's discount.

Employee's signature	Date
Spouse or qualified domestic partner's signature (if applying)	Date

SECTION 5: Beneficiary Designation *Employee completes this section.*

See "Suggested Beneficiary Designations" on pages 35-36. Include full name of beneficiary, his or her relationship to you, social security number, date of birth and whether the beneficiary is primary or secondary. You are the beneficiary for your enrolled family members.

Name	Relationship	Social security number	Date of birth	❑ Primary ❑ Secondary
Name	Relationship	Social security number	Date of birth	❑ Primary ❑ Secondary
Name	Relationship	Social security number	Date of birth	❑ Primary ❑ Secondary
Name	Relationship	Social security number	Date of birth	❑ Primary ❑ Secondary

SECTION 6: Authorization *Employee completes this section.*

By signing this form, I declare that the information I have provided is true, complete, and correct. I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits. The PEBB Benefits Services Program will verify eligibility for me and my family members. I allow my employer to deduct money from my earnings to pay for any optional insurance I requested and approved by ReliaStar Life Insurance Company. This form replaces all previous forms and submissions I have made for PEBB life insurance.

The information collected about you is confidential. We will not release any information about you without your authorization, except to conduct our business or as required or permitted by law.

Employee's signature	Date

SECTION 7: Agency/Carrier Information *Payroll or benefits office completes this section.*

Agency code _____ **Subagency code** _____ **Employee's gross annual pay** _____ **Employee hire date** _____

Insurance eligibility date _____**Date guaranteed coverage keyed into system** _____

If employee completes Section 3, send to ReliaStar Life Insurance Company to obtain approval. Date sent to carrier _____

Effective date of optional coverage(s) _____